GMSC challenges DHSS's five year cervical screening policy

The General Medical Services Committee met on 15 October with Dr John Lynch, deputy chairman, in the chair. In his opening comments to the committee Dr Lynch briefly reported the BMA council's debate and decision on testing for the human immunodeficiency virus (HIV), stating that the committee would hold a full debate on the subject at its November meeting. The council had decided that it would be undesirable in the interests of the association and of its members to implement the following resolution of the 1987 annual representative meeting: "That testing for HIV antibody should be at the discretion of the patient's doctor, and should not necessarily require the consent of the patient."

He told the GMSC that the Department of Health had rejected the committee's anxieties about the inclusion of clinical psychologists and other health professionals with no formal code of ethics as data users under the Data Protection Act.

Cervical cytology screening

The GMSC has commented on a draft circular which consolidates existing guidance on cervical screening policy and outlines a fail safe mechanism for following up smears. The committee hoped that sufficient resources would be made available to implement the proposals.

In its response the committee is to challenge the DHSS to provide the clinical evidence for its insistence on a five year screening interval—the GMSC wants tests done every three years—and to make the evidence available to the public and the profession.

Commenting on the draft reply to the department, which was before the committee, Dr Patricia Price warned that the GMSC made itself look foolish by saying that the circular did not emphasise that screening was concerned only with symptomless women. The whole emphasis was on screening and everyone knew that reference was being made to cervical screening. The draft circular stated that if a smear had been taken for a clinical reason outside the routine screening programme a new recall date should be set.

Dr D L Williams was unhappy about the paragraph in the draft circular dealing with call and recall systems. This stated, he said, that the system must cover all women aged 20 to 64 inclusive "with recall for women aged 65 and over who have not had two consecutive negative smears in the last 10 years." The only way that that could be done was to send a list to every general practitioner of those women on his or her list aged 65 and over to check that they had had two negative smears. Turning to opportunistic screening, the circular stated that all health professionals should take advantage of any appropriate opportunities to ask women whether they had been screened recently. But they never remembered when they had been screened, Dr Williams claimed, and they always got it wrong, a claim strongly refuted by Dr Fay Wilson.

There seemed to be great emphasis on the fact that unnecessary smears were taken, said Dr C R B Butler. Given the limited resources it was necessary to exercise care, but there were 17·5 million women at risk and only about three million smears taken annually. Of the two million women who died annually most had never been screened. The Medical Practitioners Union favoured family practitioner committee based call and recall systems and welcomed the use of family planning clinics and the workplace for women to be screened. That was how women in social classes four and five could be reached.

Dr George Rae agreed with the statement in the circular that health authorities should ensure that results were sent to the doctor who submitted a smear within one month; where he worked it took up to three months. Only two doctors dealt with cervical cytology in the Northern region and laboratory staff looked on cytology as a dead end job with no career prospects.

Dr P J Enoch referred to the question of the general practitioner opting out of the family practitioner committee recall system and said that the Minister for Health had put the duty on health authorities to ensure that the screening programme in the district was adequate. He hoped that general practitioners, family practitioner committees, and the authorities would collaborate to ensure that that was the case.

Dr John Lynch, deputy chairman of the GMSC.

Choice of dispenser

It is the policy of the conference of representatives of local medical committees that patients should be able to choose whether their prescriptions are dispensed by a doctor or a pharmacist. The rural practices subcommittee has reviewed this policy and recommended to the GMSC that it was politically unobtainable for patients in every part of the country to be allowed to choose whether their medication was dispensed by a doctor or pharmacist. The subcommittee also recommended that the department should be urged to give freedom of choice to patients in rural areas.

Dr Fay Wilson pointed out that the conference's resolutions were passed with particular reference to non-rural general practitioners. If the committee decided that no attempt should be made to implement the conference's policy full reasons should be given as it would also reverse the policy set out in the profession's response to *Primary Health Care: An Agenda for Discussion*.

The chairman of the rural practices subcommittee, Dr David Farrow, wondered how many doctors in urban areas wanted to dispense. His duty was to represent the views of rural practitioners and his subcommittee believed that the resolutions should be considered as applying only to rural practitioners.

The GMSC supported the subcommittee's view.

Juniors fail to get representative on MDU council

The Hospital Junior Staff Committee has failed in its attempt to secure the election of a junior doctor to the council of the Medical Defence Union. At its meeting last month the committee had been alarmed at the increasing cost of medical indemnity and wanted to get across to the defence societies the strength of feeling among junior doctors (10 October, p 939).

Over 100 doctors and dentists attended the MDU's annual general meeting on 20 October and agreed to include the junior doctors' proxies in the voting. The BMA council had agreed to mail all junior doctors asking them to complete forms of proxy (10 October, p 937). The juniors' nominee, Dr Tim Fenton, a senior registrar in paediatrics, had 1193 votes compared with the four other candidates, who polled over 8000 votes each.

The president of the MDU, Dr Derek Wylie, told the meeting that the union sympathised with the junior doctors, and he confirmed that the union planned to expand arrangements for meeting junior doctors. This would be in addition to the regular meetings held since 1983 between the HJSC and the three British defence societies.

BRIEFLY . . .

- The proposal from the Council for Postgraduate Medical Education for a district medical structure was unsuitable for general practice training, the GMSC decided, as it made no provision for general practice trainers or tutors. The committee supported the existing mechanism for monitoring training facilities based on the regional advisers and the education subcommittee.
- Some trainees in Northern Ireland have been unable to find a general practice training post after their two years in hospital posts, and the GMSC will take the matter up with the Joint Committee on Postgraduate Training for General Practice.
- The committee will shortly issue guidance to help doctors prepare evidence to the Rural Dispensing Committee when they are faced with an application by a pharmacist for permission to open a pharmacy in a rural area.

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